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IN THE COURT OF APPEAL OF THE STATE OF CALIFORNIA

FIRST APPELLATE DISTRICT

DIVISION TWO

THE PEOPLE, Plaintiff and Respondent, v. CHARLES CLEVELAND PORTER, Defendant and Appellant.	A123124 (Solano County Super. Ct. No. VC32496)

Charles Cleveland Porter appeals from an order of the Solano County Superior Court extending his commitment as a mentally disorder offender (MDO) for another year pursuant to Penal Code sections 2970 and 2972.[1] Porter contends that the trial court's finding that his severe mental disorder was not in total remission and its implied finding that it could not be kept in remission without treatment were not supported by substantial evidence. Specifically, he argues there was insufficient evidence that he failed to comply voluntarily with his treatment program during the year before the trial court recommitted him. We conclude that testimony by Porter's treating psychiatrist supported the trial court's findings, and therefore affirm.

BACKGROUND

Porter, age 56, is currently housed at Napa State Hospital (NSH) as an MDO, relating back to a 1992 offense of sexual battery (§ 243.4), to which he entered a no contest plea. Porter was initially committed under section 2962 following that conviction

[1] All statutory references, unless otherwise indicated, are to the Penal Code.

and has been recommitted numerous times under sections 2970 and 2972 based on findings that he suffers from a severe mental disorder that makes him a danger to others.

Porter's most recent involuntary commitment was to expire on November 21, 2008. On July 18, 2008, the district attorney filed a petition for continued involuntary treatment, seeking to extend Porter's commitment for another year under section 2970 et seq. The petition charged that Porter was an MDO "who, by reason of a severe mental disorder that is not in remission or cannot be kept in remission without treatment, represents a substantial danger of physical harm to others."

At a bench trial on October 6, 2008, the sole witness for the People was Porter's treating psychiatrist, Dr. Michael Gamble. Dr. Gamble testified that Porter suffers from schizoaffective disorder, bipolar type, in "partial remission." Although Porter's behavior had improved over the past year, he continued to have "symptoms of delusion, some paranoid ideation at times, and an inability so far to be able to formulate a safe discharge plan from the hospital and participate in any part of the rehabilitation program."

Dr. Gamble testified that Porter could not be kept in remission without treatment because schizoaffective disorder "is not curable." Porter's mental illness started in his 20's, and he was hospitalized more than 20 times before coming into the forensic system.

Dr. Gamble admitted on cross-examination that monthly treatment team reports prepared June 26 and July 28, 2008, indicated that Porter was "not experiencing any symptoms." However, Dr. Gamble explained that Porter's condition was not static and he had "seen [Porter] in many different moods [other] than the one described there." While Dr. Gamble was "delighted" with the lack of assaultive behavior by Porter, his compliance with medication requirements, and remission of some of his "behaviors that were dangerous," Porter "continues to have paranoia at times," as well as "tangent thought disorder symptoms" and "mood swings." The positive comments in those reports do not mean that "his thought disorder has gone away."

The chief concerns that underlay Dr. Gamble's opinion that Porter should be kept at NSH appear to have been: (1) Porter's failure to recognize that he, in fact, has a mental illness that requires medication and other treatment; (2) his refusal to acknowledge his

past criminal conduct; (3) his taking medication only under supervision, without adequate assurance that he would continue taking it if released; (4) his refusal to participate in alcohol treatment, anger management, and other group therapies recommended by his treatment team; (5) his refusal to cooperate with CONREP[2] in working toward a supervised release, rather than an unconditional release; and (6) his failure to put into place a concrete relapse prevention plan in the event of an unsupervised release.

Dr. Gamble testified that Porter "has denied that he has a mental illness. . . . [and] denied that he needs treatment." "He does take the medicine, but denies that he needs it." Dr. Gamble considered it important for Porter to "acknowledge he has a mental illness" so that he can recognize and respond appropriately to symptoms once he is released.

Porter "also denies that he committed the instant offense" and other previous crimes. Dr. Gamble was concerned that Porter would reoffend if released because he had refused to accept responsibility for his prior crimes.

Porter's treatment team had identified several discharge criteria for Porter: (1) that his behavior remain socially and sexually appropriate for six months; (2) that he engage in no assaultive conduct for six months; (3) that he avoid wheeling and dealing; and (4) that he comply with his medication and treatment regimen.

It appears that Porter had met most of these criteria at the time of trial. Dr. Gamble testified that Porter had committed no assaultive conduct for at least 18 months, and had not engaged in sexually inappropriate conduct during the 10 months that Dr. Gamble had been treating him. There had been no "wheeling and dealing."

Although Porter had been medication-compliant in the past year, Dr. Gamble noted that Porter had requested that his medication be discontinued and at times had said he does not need to take it. Asked if he believed Porter would remain medication-compliant if released from NSH, Dr. Gamble expressed the opinion that "he could not on his own do it." He based that opinion in part on Porter's past behavior, which had included "multiple hospitalizations" and assaultive behavior triggered by the

[2] CONREP is the acronym for the conditional release program.

use of alcohol. Dr. Gamble expressed the opinion that Porter was currently medication-complaint only because he was in treatment at NSH.

In addition, Porter was "not treatment compliant" in terms of recognizing the need for and participating in rehabilitation and recovery programs. When he was out in the community Porter had a serious alcohol problem, which often led to violence or other criminal conduct. Dr. Gamble testified that, despite his past problems with alcohol, Porter is "not committed to any kind of alcohol-relapse prevention, and he's not [even] able to say, 'I have an alcohol problem.' " Porter had not been able to assure Dr. Gamble that he would not drink alcohol if released. The treatment team wanted him to participate in a substance-abuse recovery program, a medication class, and an anger management group. Porter's participation in these types of recovery programs was "almost nil," and he denied any need for such programs.

Of further major concern was that Porter had not been able to develop, and had denied the need to develop, criteria for a safe discharge plan. This failure to have a relapse plan in place was worrisome to Dr. Gamble because "prevent[ing] relapse with the understanding of his illness . . . is the hallmark of what we're trying to do with people . . . ."

Dr. Gamble also opined that Porter "could not manage . . . being in an unsupervised kind of structure." Even if he were to be released, he would need "the protection of CONREP or some other intermediate step." Porter would pose a risk to the public "if he doesn't have more structure around him or on-going treatment assured." Nevertheless, Porter "has refused to have anything to do with CONREP" and was "[v]ery actively oppos[ed]" to conditional release.

Dr. Gamble acknowledged that Porter had held a job for the past year, where he had received favorable evaluations for cooperation, independence, and follow through. The job was a stabilizing influence for him. Porter had also earned a ground card allowing him to go outside his unit to attend activities and work, and he participated occasionally in athletics. These strides, while encouraging, were not enough to change Dr. Gamble's opinion that Porter was not ready for release.

Porter then testified on his own behalf. He confirmed that he had not had any incidents of violence or other misconduct in the past year. He also described his work building electrical circuits at Solanics on the NSH grounds. He was working four days a week and had previously worked five days a week.

When asked if he suffered from a mental illness, he answered, "I imagine so, yes." He acknowledged having been told he was "delusional, bipolar [and] anti-social," and he was willing to "settle for what the doctors said." He noted, however, that such words are "irrelevant" to him and that he had been allowed to enter the United States Army despite his mental illness. But he was "not questioning" the doctors' diagnosis.

Porter testified that he takes medication "so [he] can stay in remission." He identified his medications as Ativan, Depakote, and Stelazine. He indicated he would be willing to continue taking his medication if released and would get it from a psychiatric clinic, paid for by Medi-Cal or Medicare. If he experienced symptoms after release he said he would "[s]eek out the doctor" at the clinic. In terms of relapse prevention, his main plan appeared to be to remain medication-compliant.

Porter's brother had agreed to allow him to live temporarily in his three-bedroom trailer in Clearlake Park in Lake County, but Porter eventually wanted to move back to Vallejo, where he believed he would have better luck finding work. He would seek out jobs doing landscaping, painting, pruning trees, or roofing. He would also apply for SSI, disability benefits, and food stamps. He further claimed he is "pretty good" at "draw[ing] portraits" and might be able to make money doing that when he "can't work any more."

Porter denied that he would use alcohol if released, claiming it "would be too fatiguing" and, having "been without it for 18 years," he has "no desire" to drink. He also vowed that he would stay away from illegal drugs because they could be a threat to his health and life, given his preexisting hypertension. He acknowledged past problems with alcohol, but would avoid drinking and taking drugs if released because he realized they would tend to "make [him] gullible enough to try something foolish."

He testified that he had known the woman he assaulted in 1992 since 1970. He did not acknowledge his crime, saying "Did you see it, or did anyone else see it?" He said he "loved the girl" and "pleaded no contest to keep her out of [c]ourt."

When asked whether he would be willing to be released through CONREP, he said he would "[n]ot willingly" participate, but "if I have to, um, I would have to." One of his concerns was that he would "[b]e under constant scrutiny all the time" and would "have to take more meds on top of meds where I drool and stumble and sleep and fall all day long." He claimed CONREP had not contacted him in the past year about possible supervised placement.

At the trial's conclusion, the court offered to appoint an independent doctor to evaluate Porter. The court thought Porter's testimony had "some merit," but it was "interested in getting an independent assessment from a doctor who's not from Napa State Hospital." Porter declined that offer.

After hearing argument from Porter's counsel, the court found true the allegations of the petition and issued an order extending Porter's MDO commitment until November 21, 2009. It made the following findings:

"I'll find Mr. Porter does suffer from a severe mental disorder or defect that is not in total remission, although I'll say it's been kept in remission with treatment, and that he does represent a substantial danger of physical harm to others.

"I'll extend his commitment for one year from November 21, 2008 to November 21, 2009, pursuant to Penal Code Section 2972.

"Having said that, I think Mr. Porter is very close."

The clerk then asked whether the court wanted to issue an order for involuntary medication, as had been done the preceding year, but the court declined to do so.

DISCUSSION

Porter claims on appeal that there was insufficient evidence for the trial court's "implied finding" that his mental disorder "cannot be kept in remission without involuntary treatment." Section 2972 provides for the recommitment of an MDO if the court finds beyond a reasonable doubt that "the patient has a severe mental disorder, that

the patient's severe mental disorder is not in remission or cannot be kept in remission without treatment, and that by reason of his or her severe mental disorder, the patient represents a substantial danger of physical harm to others." (§ 2972, subds. (a), (c).)

Section 2962, subdivision (a) defines key terms governing the civil commitment of MDOs, as follows: "The term 'remission' means a finding that the overt signs and symptoms of the severe mental disorder are controlled either by psychotropic medication or psychosocial support. A person 'cannot be kept in remission without treatment' if during the year prior to the question being before . . . a trial court, he or she has been in remission and he or she has been physically violent, except in self-defense, or he or she has made a serious threat of substantial physical harm upon the person of another so as to cause the target of the threat to reasonably fear for his or her safety or the safety of his or her immediate family, or he or she has intentionally caused property damage, or he or she has not voluntarily followed the treatment plan. In determining if a person has voluntarily followed the treatment plan, the standard shall be whether the person has acted as a reasonable person would in following the treatment plan."

In MDO recommitment proceedings, we review the trial court's findings for substantial evidence—that is, evidence which is reasonable, credible, and of solid value—drawing all reasonable inferences, and resolving all conflicts, in favor of the judgment. (*People v. Martin* (2005) 127 Cal.App.4th 970, 975; *People v. Beeson* (2002) 99 Cal.App.4th 1393, 1398 (*Beeson*); *People v. Miller* (1994) 25 Cal.App.4th 913, 919-920.)

Preliminarily, although the parties have not discussed this issue, it appears to us that the order extending Porter's commitment should be affirmed based on the court's finding that Porter's severe mental disorder "is not in total remission." The statute is phrased in the disjunctive, so that recommitment is authorized either (1) if the patient is not in remission; or (2) if he or she "cannot be kept in remission without treatment." (§ 2972, subd. (c).) Indeed, the NSH official who referred the case to the district attorney requested recommitment based on the first of these prongs, not the second. The parties' briefing in this court has focused exclusively on the second prong, but the trial court's

finding on the first prong, if supported by substantial evidence, would be legally sufficient to justify the recommitment order.

There was substantial evidence to support a finding that Porter was not in remission based on Dr. Gamble's testimony that Porter was in "partial remission" but continued to have "symptoms of delusion [and] some paranoid ideation at times," as well as "tangent thought disorder symptoms" and "mood swings." Certainly these thought and mood disorders would be considered "overt signs and symptoms" of his severe mental illness so as to support the court's finding that Porter is "not in total remission."

Nevertheless, Porter argues that because the court went on to say that Porter's mental disorder has "been kept in remission with treatment," that finding essentially trumps the immediately preceding finding that his mental disorder is *not* in remission. He argues that the court's statements boiled down to a finding that Porter's illness "*was* in remission at the time of trial." (Italics added.)

This logic eludes us. Though the court's observation that Porter's illness has "been kept in remission with treatment" might, standing alone, constitute an implied finding that Porter was "in remission" at the time of trial, we cannot endorse such an interpretation when that "implied finding" is juxtaposed against the express finding that Porter was "not in total remission." Since the court specifically found that Porter's illness "was not in total remission" but was "kept in remission with treatment," it appears that the court intended to convey that most, but not all, of the signs and symptoms of the illness were kept in remission with treatment. Although the court could have more artfully framed its findings, we do not think the language "it's been kept in remission with treatment" can fairly be read as overriding the immediately antecedent explicit finding that the illness was "*not* in total remission."

Nevertheless, in light of the parties' exclusive emphasis on the second prong of the statute, we will also examine whether there was substantial evidence to support what Porter calls the court's "implied" finding that his illness "cannot be kept in remission without treatment." On that ultimate question, Dr. Gamble's testimony unequivocally

supports such a finding. When asked whether Porter could be kept in remission without treatment, he responded emphatically, "Absolutely not."

As noted above, section 2962, subdivision (a), lists four circumstances under which a person may be recommitted in spite of being in remission: (1) engaging in unexcused physical violence; (2) making a serious threat of substantial physical harm to another; (3) intentionally causing property damage; or (4) not voluntarily following the treatment plan. If the state proves any of these four criteria, the patient, by statutory definition, " 'cannot be kept in remission without treatment.' " (*People v. Burroughs* (2005) 131 Cal.App.4th 1401, 1404-1407.)

The parties agree that only the fourth criterion would potentially apply to Porter. We therefore address whether the evidence supported an implied finding that Porter had not "voluntarily followed the treatment plan" during the year preceding his recommitment.

Applying a reasonable person standard, as required by section 2962, subdivision (a), there was substantial evidence to support such a finding. Dr. Gamble testified that Porter had denied his need for medication during the preceding year, and based on Porter's past history, he believed Porter would not remain medication-compliant if released without supervision. In addition, it must be noted that Porter had been under an involuntary medication order during the preceding year, and it is difficult to assess what role that may have played in his compliance with medication requirements during that period. Since the court declined to renew the involuntary medication order at the October 2008 hearing, the next year will give a better indication whether Porter is truly in voluntary compliance with his medication requirements.

But more pertinent still is the fact that Porter was not in voluntary compliance with non-medication aspects of his treatment plan. The statute requires voluntary compliance with the entire "treatment plan," not simply its medication requirements. The evidence was uncontroverted that Porter had refused to participate in group recovery and rehabilitation programs, including those addressing alcohol and substance-abuse,

medication, and anger management. Porter's refusal to participate in such recovery programs constituted a failure to "voluntarily comply" with his treatment plan.

Both parties rely largely on *Beeson, supra*, 99 Cal.App.4th 1393, which held as follows:

"Under section 2962, not voluntarily following the treatment plan is essentially an exception to the finding that the illness is in remission. The Legislature listed several circumstances that would indicate that a person's illness could not be kept in remission by treatment. Even when a person does not exhibit violent or threatening behavior, his failure to participate in his treatment plan also may reveal whether he can reenter society without the constraints and protections afforded in a structured environment. In other words, rather than relying on the presence of overt symptoms, the Legislature provided additional factors in gauging a person's current condition. Such factors are not intended to be superfluous or meaningless. As stated above, the statute clearly provides that a person's failure to voluntarily follow his treatment plan may be grounds for a finding that he cannot be kept in remission without treatment." (*Id.* at p. 1400, fn. omitted.)

Beeson is similar to the instant case in that it involved a schizophrenic patient who at times "denied having a mental illness" and at others told his psychiatrist **"**he did not need his medication." (*Beeson, supra,* 99 Cal.App.4th at pp. 1397-1398.) Beeson "did not have a relapse prevention plan" and "resisted treatment by refusing to attend therapy sessions." (*Id.* at p. 1398.) In these quite similar circumstances, the Fourth Appellate District held that the state had carried its burden of proving that the patient could not be kept in remission without treatment. (*Id.* at p. 1401.)

"Although [Beeson] argue[d] that any lack of cooperation was well within what would have been expected of a reasonable person, the People's evidence indicates that defendant was inconsistent in acknowledging his mental illness and his need for medication and treatment. A reasonable person, whose mental disorder can be kept in remission with treatment, must, at minimum, acknowledge if possible the seriousness of his mental illness and cooperate in all the mandatory components of his treatment plan." (*Beeson, supra*, 99 Cal.App.4th at p. 1399.)

Porter attempts to distinguish *Beeson* based on the fact that Beeson's treating psychiatrist testified that his "treatment plan consisted of various components, including medication, therapy, and mandatory and recommended group meetings and activities," that Beeson "was sporadic or inconsistent in his attendance and level of participation at certain meetings," that he "had failed to cooperate fully during his psychological evaluation," and "[o]n another occasion, [Beeson] stopped attending group meetings with a rehabilitation therapist because he believed that the therapist was criticizing or picking on him." (*Beeson, supra,* 99 Cal.App.4th at pp. 1399-1400.)

We cannot agree that this testimony materially distinguishes *Beeson* from Porter's case. The testimony regarding Beeson's lack of cooperation in treatment and lack of insight regarding his mental illness was comparable to that of Dr. Gamble in this case. Like Beeson, Porter "has denied that he has a mental illness. . . . [and] denied that he needs treatment." While Porter took his prescribed medication, he "denies that he needs it." He refused to acknowledge that he had a problem with alcohol and was "not committed to any kind of alcohol-relapse prevention," being unable even to assure Dr. Gamble that he would not drink if released. And though his treatment team wanted him to participate in a substance-abuse recovery program, a medication class, and an anger management group, Porter's participation in such recovery programs was "almost nil," and he denied any need for such programs. The similarities between the testimony in this case and that in *Beeson* strengthens our conviction that any implied finding that Porter had not voluntarily complied with his treatment plan was supported by substantial evidence.

It is also noteworthy that Beeson presented the testimony of an independent psychiatrist, who voiced the opinion that Beeson had complied with his treatment program as a reasonable person would. (*Beeson, supra,* 99 Cal.App.4th at pp. 1398, 1400.) Even this countervailing medical opinion did not overcome the treating psychiatrist's opinion that Beeson had not voluntarily complied with his treatment plan.

No similar expert opinion was presented on Porter's behalf. Instead, Porter's own testimony stood alone in contrast to Dr. Gamble's expert opinions. Porter's own

testimony tended to rebut Dr. Gamble's assertions that Porter did not acknowledge his mental disorder, would not willingly comply with his medication requirements if granted unsupervised release, was vehemently opposed to placement through CONREP, and was at risk for alcohol or drug relapse if returned to the community. The trial court was not bound, however, to credit Porter's testimony over Dr. Gamble's. The fact that Porter disputed the doctor's predictions does not deprive those opinions of their status as reasonable, credible, and solid evidence. Porter's testimony also shows that he had given some thought to where he would live and how he would support himself if released, but that does not necessarily amount to the formulation of a "safe discharge plan" that Porter's treatment team deemed necessary to prevent a reversal of his progress in dealing with his mental illness and to protect the community. The court's findings and its recommitment order were supported by substantial evidence.

DISPOSITION

The recommitment order is affirmed.

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Richman, J.

We concur:

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Kline, P.J.

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Haerle, J.